UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

SCOTT GRANT, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C02-3071-MWB **REPORT AND RECOMMENDATION**

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V. CONCLUSION

The plaintiff Scott A. Grant ("Grant") appeals the Commissioner's decision denying him Title II disability insurance ("DI") benefits for the period from November 2, 1998, to January 1, 2000.

I. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On August 11, 1999, Grant filed an application for DI benefits, alleging a disability onset date of November 2, 1998. (R. 113-15) The application was denied initially on September 30, 1999 (R. 99, 102-05), and on reconsideration on March 8, 2000 (R. 100, 107-11). On March 28, 2000, Grant requested a hearing (R. 112), and a hearing was held before Administrative Law Judge (ALJ) John P. Johnson on August 9, 2000, in Clear Lake, Iowa. (R. 52-98) Attorney Blake Parker represented Grant at the hearing. Grant and his wife, Diane Grant, testified at the hearing, as did Vocational Expert ("VE") G. Brian Paprocki.

On November 21, 2000, the ALJ ruled Grant was not entitled to benefits. (R. 21-32) On November 22, 2000, Grant requested review of the ALJ's decision. (R. 12-14) The Appeals Council of the Social Security Administration granted the request for review on August 10, 2001. (R. 15-16) The Appeals Council considered the arguments of counsel and additional evidence submitted by Grant, and also obtained a further consultant's review of the evidence (*see* R. 10, 296-342). On August 2, 2002, the Appeals Council overruled the ALJ's decision in part, finding Grant to be disabled from and after January 1, 2000, and affirming the ALJ's decision that Grant was not disabled from November 2, 1998, to January 1, 2000. (R. 5-11)

Grant filed a timely Complaint in this court on March 28, 2003, seeking judicial review of the denial of his application for DI benefits for the period prior to January 1, 2000. (Doc. No. 1) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge, pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Grant's claim. Grant filed a brief supporting his claim on May 12, 2003. (Doc. No. 12) The Commissioner filed a responsive brief on July 7, 2003. (Doc. No. 13). Grant filed a reply brief on July 15, 2003. (Doc. No. 13) The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Grant's claim for benefits.

B. Factual Background

1. Introductory facts and Grant's daily activities

a. Grant's testimony

At the time of the hearing, Grant was 42 years old. He was 5'9" tall and weighed 228 pounds. He obtained a GED in 1978, and then, in 1992, he received a two-year degree in retail merchandising from a community college. (R. 57, 70) Grant lives with his wife Diane Grant ("Diane"), who works as a dispatcher for the Algona Police Department. (R. 57, 82) He stated Diane does all the driving because he cannot drive due to seizures. He lost his license about a year before the hearing because, according to Grant, the law changed regarding the visual acuity required for a license. (R. 57) He stated he is unable to see out of the left side of each eye, but he can see out of the right sides of his eyes. The loss in visual acuity was the result of surgery he had in 1994. (R. 81) He is able to read if he holds the page off to his right side, but it tires him. Similarly, to write, he stated he makes sure the paper is over to his right side so he can see where to write. (R. 58) He is able to use a computer, although he does not have a computer at

home. (R. 58, 82) He has some difficulty judging depths, but no difficulty seeing at night. (R. 82)

Grant explained he has suffered from epileptic seizures since he was six years old. He could not point to anything in particular that brings on his seizures. He had what he described as a "bad" seizure the day before the hearing, and stated he had not had a bad seizure for a long time prior to that. He had no idea what happened during the seizure, but stated Diane was present and would be able to testify about what happened. He stated he does not typically seek medical treatment at the time of a seizure, and his doctors have not directed him to go to the hospital when he has a seizure. (R. 59)

Grant stated he has some warning prior to a seizure, which he described as "a very faint fetal like sensation coming over [him]," starting at his forehead and working back slowly. (R. 60) These feelings begin from 30 seconds to five minutes before the onset of a seizure. He stated when he feels a seizure coming on, there is nothing he can do to stop the seizure except make sure he is sitting down, noting it would take half an hour for any medication to begin working. (R. 61) Grant stated he has small seizures about once a week, and he is aware of what happens during those seizures, which typically last from one to two minutes. He feels the warning sensation, and then he gets very tired and feels like he is "dragging." (R. 61, 81) He has to sit down, and when the seizure is over, he immediately has to urinate, he is thirsty, and he will have a small headache. (R. 61-62) It will take him three to four hours to get over one of the smaller seizures, during which time he has to rest and sleep. (R. 61) After a larger seizure, it will take him about eight hours to recover.

Grant stated he is under the care of Dr. Jeffrey Britton from the Mayo Clinic. Grant takes Midrin for migraine headaches. He also takes therapeutic levels of anti-seizure medications, and he is careful about taking his medications as directed. Dr. Richards in

Algona, Iowa, monitors his blood levels every two months. (R. 62, 64) He stated none of his medications cause him any problems. (R. 78)

Grant had surgery to try to alleviate the seizures, and he stated the surgery was successful for awhile, and then the seizures started happening again.[1] (R. 63) He was hospitalized in January 2000, at the Mayo Clinic, for further testing. While he was at the hospital, he had a major seizure that caused him to bite his tongue and wet the bed. Until this seizure, he had not had a major seizure since his surgery. (R. 64) In May 2000, he had another seizure that required hospitalization. (R. 78)

Grant testified he also suffers from low back pain. He explained he farmed from 1985 to 1998, and he pulled a muscle early in his farming career. (R. 65, 71) He has pain that sometimes feels like a knife sticking into his lower back, and the pain will shoot down into his foot. (R. 65) He tries to keep the area loosened up by moving around and exercising. His back condition was treated by Dr. Richards for awhile, and then Dr. Britton referred him to another doctor. He stated in January 1999, at the Mayo Clinic, he had "a test where they used electrical shock to find exactly where [the pain] was coming from," and then he was given "a cortisone shot right into the area of the problem." (R. 66, 77) The shot provided quite a bit of relief from the pain, and he has had no further treatment for his back pain. (*Id.*) Grant stated he quit farming because travel from Algona to the farm was a problem, and he and his father were concerned about the dangers inherent in farming due to Grant's seizures. (R. 66-67) He stated that when he was farming, he ran a cultivator and drove a tractor, hauled grain to the elevator in town, and lifted up to 60 pounds. (R. 71)

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[1]The Record indicates Grant's surgery was on December 8, 1994, when he underwent resection of the right occipital area of his brain. (*See* R. 304)

Grant testified his back pain sometimes causes him problems walking. His muscles will tighten up and cause him to stumble, but once he gets his footing, he can walk without difficulty. (R. 78-79) He estimated he can stand for about an hour, but then his back will hurt and he will have to change positions. He can bend at the waist, but stated it "pulls that muscle," and he does not feel he could bend at the waist repeatedly. (R. 79) He has no problem stooping or squatting, but again felt if he did those activities repeatedly, his back muscles would tighten up. He has no difficulty climbing stairs or using his hands. (*Id.*) He stated he can sit from one to two hours at a time before his back muscles will tense up and give him problems. He has no difficulty using his arms, pushing and pulling, or reaching over his head. (R. 80)

Grant stated that at the time he had the steroid injection in his back, the physical therapist limited his lifting to 40 pounds. He confirmed he could lift 40 pounds, but opined that if he lifted more than that, he would "pop a muscle in the back." (*Id.*)

Grant discussed various other jobs he has performed in addition to farming. In September 1991, he worked briefly at McDonald's. He cleaned equipment, mopped floors, made french fries, took orders, and ran a cash register. The job required him to lift from 10 to 20 pounds. (R. 159) He initially stated he left when management told him they had "promised the job to someone else, and they forgot," but he suspected he was fired because of his seizures. Although he did not have a seizure while he was there, he stated his mother-in-law planned to tell McDonald's about his seizure disorder. (R. 67-68) Later, in response to the ALJ's questioning, Grant explained he left the job because his "grades were started to fall in college, so [he] had to make a choice to either keep [his] grades up or have them go down fa[r]ther, and [he] wanted to keep them up instead." (R. 75)

From 1991 to 1993, Grant worked as a salesperson for Electrolux. He did some door-to-door sales, and also went on arranged appointments. He had to lift about 40 pounds, and did paperwork that included filling out sales receipts and credit card receipts. He worked "most of the day for about four days a week." He stated he was "[n]ot very good" at the job and never made over $500 a month. (R. 75-76)

From May 1993 to August 1996, and April 1997 to August 1999, Grant worked as an animal control officer for the City of Algona, Iowa. (R. 69, 76-77, 155-56) He stated he would stay at home and wait for a call from the dispatcher, and then respond to the call. Sometimes he would have to chase down a cat or dog, or trap and transfer a woodchuck or raccoon. He also tended the animals in the animal shelter, making sure they had food and water, and spraying down the kennels to clean them out. He was required to lift cages and animals, and estimated he would lift from 25 to 120 pounds. (R. 76-77, 156) The job required him to do some paperwork, as well. (R. 76) Grant stated the job required a driver's license, and he had to leave the job when he lost his license approximately a year prior to the ALJ hearing. (R. 69)

Grant worked at Pioneer Hi-Bred for three or four months in 1994, monitoring the operation of a bagging machine. He testified the job required him to lift from 30 to 65 pounds. (R. 71-72) However, on the Work History Report he completed in August 1999, Grant estimated he had to lift 50 pounds regularly, and occasionally up to 120 pounds. (R. 161)

In May 1996, Grant worked at A-1 Processors as a bagger, tying off bags and running them through a sewing machine. The bags weighed 20 to 30 pounds each, and the work was manual labor. (R. 73, 155)

From June to July 1996, Grant worked briefly as a meat cutter in a grocery store. (R. 74, 155) He would grind hamburger, roast chickens and ribs, stock shelves, and clean

up. He was required to lift meat onto shelves one day a week. (R. 158) He testified the job required him to lift from 40 to 60 pounds; however, on his Work History Report, he estimated he lifted 25 pounds frequently, and at times lifted up to 100 pounds or more. (R. 74, 158) He stated he was fired because he never got trained. (R. 74)

From July to August 1996, Grant worked at a telemarketing firm doing credit card solicitations. (R. 68, 155) He stated a Mayo Clinic doctor told him the job was causing too much strain on his eyes and advised him to quit. (R. 68)

From August to September 1996, Grant worked in a chicken hatchery as an "egg flipper," where he would take incubated eggs, put a crate over them, and "flip them so then they could hatch out." (R. 74, 155) The job required lifting 20 to 25 pounds frequently, and occasionally up to 50 pounds. (R. 74, 160)

From September to October 1996, Grant again worked at Pioneer, this time as a sorter. (R. 72, 155) He explained he would pull out bad ears of corn, and make sure the right variety of corn went into the correct dryer. The job was seasonal and ended at the end of harvest time. (R. 72-73)

Grant stated he does not believe he could do any type of work other than a woodworking hobby he has at home. If he could get his seizures under control, then he opined he might be able to convert his hobby into a full-time business and sell his wood work. However, when he gets hot, he has to go inside. (*Id.*) He explained his woodworking projects are not large; he makes picture frames. (R. 84)

Grant described a typical day, stating he normally gets up around 10:00 a.m. and goes to bed around 12:00 a.m. He has trouble getting to sleep, stating he has to wind down from the day. (R. 83) He can bathe, dress, and feed himself without assistance. When he gets up, he sometimes eats breakfast, and he spends the morning planning what he is going to do that day. He eats lunch, and then, depending on how he is feeling, he

might do some cleaning around the house, or work on a wood shop project. (*Id.*) After supper, he watches TV, or if his wife is home, they talk. When he does housework, he can vacuum, dust, or do "basically whatever needs to be done in the house." He and his wife both take care of the lawn and outside work. (*Id.*)

Grant is a member of an organization called "the chips off the old block." The group meets once a month. He has to get rides to the meetings. (R. 84)

B. Diane Grant's testimony

Diane testified she is Grant's wife and has lived with him for nine and one-half years. (R. 84-85) She has seen him have seizure-free periods, and also periods when he is having seizures. She stated that Grant's 1994 surgery was successful for awhile, but he started having seizures again after a year or two. She stated Grant has had "grand mals, multiple seizures that are fairly mild, then last about three or four minutes maybe," and he had been having small seizures once or twice a week for several months prior to the hearing. (R. 85) She described Grant's seizures, stating "[h]is mouth starts working like he's chewing gum, or he's trying to get something stuck off his teeth. His left hand usually comes up and moves toward his right, across his chest, and usually his head will turn to the right." (R. 86) She is not sure if Grant knows what is happening during a seizure, but stated she will talk to him and he will not respond. (*Id.*) When the seizure ends, she stated Grant is "usually kind of confused looking for a few minutes. He can talk to you, but he doesn't make a whole lot of sense." (*Id.*) The confusion will last about five minutes, and then Grant will get a headache that lasts for several hours. He takes Midrin and Tylenol for the headache, and sometimes will lie down and nap for awhile. (*Id.*) Diane stated she had never observed Grant having a grand mal seizure, but she has seen him have seizures that last a bit longer than the three-minute seizures. (*Id.*)

Diane stated Grant went to the Mayo Clinic for testing in May 2000, and he had a seizure about an hour after he arrived, before any of the testing had started. Then doctors took Grant off his medications and waited for another seizure to occur so they could do the testing. The doctors were unable to do the test because Grant's next seizure occurred at 5:00 a.m., and the technicians who do the test are only at the hospital from 7:00 a.m. to 11:00 p.m. They offered Grant the opportunity to remain at the hospital until they were able to test during a seizure, but by that time he had already been in the hospital for ten days and he wanted to go home. She stated they planned to return to the hospital at the end of September for more testing. (R. 87)

Diane confirmed that Grant is unable to see on his left side. She stated if someone is walking next to him, he will not know they are there and will bump into them. She stated his personality and mental functions have not changed, but they are concerned because the seizures have resumed. (R. 88)

2. Grant's medical history

The Record indicates Grant underwent an occipital lobe resection for medically intractable seizures in December 1994. (R. 332-33) One side effect from the surgery was complete homonymous hemianopsia (*i.e.*, complete vision loss in the left visual fields of both eyes). (R. 304, 334) Grant remained seizure free until August 1996, when he had a recurrence of seizures, apparently due to a low Phenytoin level. He saw Frank Sharbrough, M.D. at the Mayo Clinic for follow-up, and the doctor increased Grant's Phenytoin. Dr. Sharbrough noted that if Grant's seizures recurred, they would consider restarting Felbamate because Grant had done well on the drug prior to his surgery. (R. 304, 334) In August 1997, there is a notation that a prescription for Felbamate was refilled, implying the Felbamate was, indeed, restarted at some point due to a recurrence

of seizure activity. (R. 247) At a follow-up visit on September 9, 1997, Dr. Sharbrough noted Grant "had some sporadic seizures" following the 1994 surgery, including "possibly one complex partial seizure in July of 1997," but he had remained seizure-free since that time after restarting Felbamate. (R. 246, 305)

Grant continued to have regular checkups to follow his seizure disorder, and there are repeated indications in the Record, from both Grant's treating physicians and the medical consultants, that he remained seizure free from July 1997 until September 1999. (*See id.* - patient seizure and aura free since July 1997; R. 242-43, 306-07, 06/04/98 - no seizures over past year; R. 236-37, 308-09, 06/24/99 - patient doing well with seizures and complying with medication regimen; R. 264, 09/21/99 - patient's seizure disorder is under good control)

During the same period of time (*i.e.*, 12/94-9/99), Grant also began complaining of problems with his neck, shoulders, and back. The first evidence in the Record is at a follow-up visit with Dr. Sharbrough on September 9, 1997, when Grant complained of intermittent neck and right arm pain for "the past five years." He stated the pain was aggravated by turning his head. The doctor noted, "There has never been any associated neurologic deficit." (R. 246) Dr. Sharbrough prescribed physical therapy, and Grant saw a physical therapist on September 15, 1997, for instruction in range of motion exercises and relaxation exercises. He also was directed to use heat on the affected areas. (R. 249-50) The next day, Grant called the doctor's office to report that the physical therapy exercises requiring him to tip his head way back caused him to feel light-headed. A doctor recommended Grant not do those particular exercises. (R. 245)

Grant saw Burt J. Bottjen, M.D. at the Kossuth Regional Health Center on May 20, 1998, complaining, among other things, of low back pain for several months, mainly on the right, and occasional numbness in his foot. Dr. Bottjen diagnosed him with

"[m]echanical back pain (normal reflexes, normal sensation in the lower extremities)." (R. 218) He advised exercises and stretches, and stated, "I told him I didn't think this is a disc problem, but more mechanical." (*Id.*) He also advised Grant to lose 30 pounds. (*Id.*)

On April 7, 1999, Grant saw Stephen D. Richards, D.O., at the Kossuth facility, again complaining of low back pain. Dr. Richards noted Grant had injured his back muscles "several times in the past." (R. 215) He diagnosed a low back strain and offered physical therapy, but Grant declined, stating he wanted to try home therapy with heat and massage. (*Id.*)

On September 18, 1999, Dennis A. Weis, M.D. completed a Physical Residual Functional Capacity Assessment form for Grant (*see* R. 256-63). From reviewing Grant's medical records, Dr. Weis noted that Grant reported having "back, shoulder, neck pain, sharp spasms, aggravated by cold weather and vibrations on nearly a daily basis." (R. 264) Grant reported that Tylenol did not work well for him. He also stated he had some difficulty doing yard work and home repairs, and some trouble sleeping, but Dr. Weis noted, "He does not indicate that this is due to pain." (*Id.*) Dr. Weis found that a lack of "specific evidence of motor or neurologic defect" significantly eroded Grant's credibility regarding his orthopedic complaints. (*Id.*)

On October 11, 1999, Grant saw Dr. Richards again, complaining of low back pain that radiated down the inside of his right leg. He stated the pain "started getting worse about three weeks ago," with no identifiable incident causing the exacerbation of his symptoms. (R. 266) The doctor diagnosed him with right sciatica, and prescribed Celebrex and physical therapy. (*Id.*)

On October 22, 1999, Grant called Jeffrey W. Britton, M.D., at the Mayo Clinic, and reported having a seizure in September, and another seizure on October 13, 1999. He

had not changed his medications. He was told to have his blood levels drawn, and he was scheduled for an appointment with the doctor to consider treatment options. (R. 266)

On October 27, 1999, Grant called Dr. Richards to report physical therapy was not helping his back and leg pain. The doctor scheduled an MRI of Grant's lumbar spine. (R. 266)

On November 1, 1999, Grant saw Dr. Britton for a follow-up of the recurrence of his seizure activity. Grant reported having three seizures in the previous month, two of which were witnessed by his wife. (R. 309) (It appears a page may be missing from the Record, as no treatment notes appear with this entry.)

Grant underwent an MRI of his lumbar spine on November 8, 1999. The MRI revealed "some 'hard' disk degeneration of the L4-5 and L5-S1 segments with broad based subligamentous disk-osteophyte complexes but without evidence of disk herniations or any bony or soft tissue stenosis or encroachments of spinal canal and contents or vertebral foramina bilaterally." (R. 268) Grant also apparently had an EMG of his back. When Grant saw Dr. Britton for follow-up on November 16, 1999, the doctor noted EMG findings showed "active radiculopathy on the right at L5," which was "rather chronic" and "on the milder side." (R. 310) He noted the MRI showed no obvious disc herniation, but did show a disc bulge at L4 and L5 with some foraminal encroachment bilaterally at those levels. Dr. Britton referred Grant to W.R. Marsh, M.D. to review his case and recommend further treatment. (*Id.*)

At the same appointment, Grant and Dr. Britton also discussed Grant's seizure disorder. An EEG showed "continued potentially epileptogenic activity in the right posterior head region." (*Id.*) The doctor noted some cerebral changes in the right posterior parietal regions since the 1994 surgery. Treatment options were discussed, and

they decided Grant would be admitted for EEG monitoring, with the possibility of intracranial monitoring prior to further surgery. (R. 310-11)

Grant saw Dr. Britton again on November 30, 1999, and reported having a partial seizure a week earlier during a bad cold. He had been seizure free since then. He stated he woke up in the morning with a headache and assumed he had had a seizure during the night; however, no seizure was witnessed by his wife. He was advised to continue his current medications, and return in six months for routine follow-up. He was cautioned to contact the doctor's office if he continued to have seizure activity. (R. 311)

Grant also saw Dr. Marsh on November 30, 1999. He described daily, constant pain in his back, right buttocks, and right leg, worsened with weight bearing. He reported the pain limited his walking and interfered with his sleep. The doctor discussed treatment options with Grant, who inquired whether surgery was feasible. The doctor scheduled a myelogram for December 9, 1999. (R. 310) The court has not located any report from the myelography in the Record.

According to the Record, Grant's next follow-up exam for either his seizure disorder or his back problems was April 21, 2000, when he saw Dr. Britton for follow-up of his seizure disorder. (R. 312-13) The Record indicates Grant underwent EEG monitoring in May and October 2000, including placement of subdural grid and strip electrodes with intracranial monitoring in October 2000. A left vagal nerve stimulator was implanted. Grant has continued to receive regular follow-up care for the seizure disorder, and the Record supports the Appeals Council's conclusion that Grant was disabled due to seizures. Because the appeal presently before the court concerns only the period from November 2, 1998, to January 1, 2000, the court will not summarize the remaining medical evidence in the Record.

3. Vocational expert's testimony

The VE stated he had reviewed Grant's file and all of the exhibits prior to the hearing. In response to the VE's questioning, Grant explained that when he worked for Pioneer monitoring the bagging machine, he had the option of sitting or standing. (R. 89) The VE created a chart to summarize Grant's past relevant work, and the summary was entered into evidence at the hearing. (*See* R. 201-02)

The ALJ asked the VE the following hypothetical question:

> I'd like you to respond directly to the case picture as presented and not allow any extemporaneous matter to influence you. My first assumption is that we have an individual who is 35 years old – excuse me, that's not right – he's 42 years old as of the alleged onset date of disability. He's a male, he has a high school education and an associate of arts degree in retail merchandising, he has a seizure disorder, he has degenerative disc disease of the lumbar sacral spine resulting in complaints of low back pain, and he had left [homonymous hemianopsia], and as a result of those impairments he has the residual functional capacity as follows: he cannot lift more than 20 pounds, routinely lifting 10 pounds; he cannot stand for more than an hour at a time, sit for more than one to two hours at a time, or walk more than block – one mile – at a time. He should perform no work which requires repetitive bending, stooping or squatting. No continuous kneeling or crawling. He should not work at unprotected heights or around hazardous moving machinery, and he should perform no work which requires depth perception or full visual fields. He also should not be exposed to excessive heat or humidity. Would this individual be able to perform any job he previously worked at, either as he performed it, or as it is generally performed within the national economy?

(R. 91) The VE responded that with those limitations, Grant would be able to return to his job monitoring the bagging machine at Pioneer, with the opportunity to sit or stand.

He also should be able to do telemarketing jobs that allow "at least a limited amount of time to change position, take short breaks." (*Id.*)

The VE opined further that even if Grant could not perform his past relevant work, someone with Grant's education and skills acquired during his past work would be able to work as a record clerk, sorter, checker, or document reviewer (for example, for an insurance company, reviewing applications that come in for completeness, rather than for substance). The VE noted these are sedentary jobs where the primary work is seated, but the jobs would allow for routine positional changes. (R. 93) The VE stated the hypothetical individual also would be able to work as a check cashier (for example, working at a power company and receiving payments on billings) and an auction clerk. (R. 93-94) The VE noted his opinions took into consideration the fact that the individual lacked vision on the left side. (R. 95)

The VE stated that if the individual were unable, for medical reasons, to work at a computer, then some of the jobs listed would be precluded. (*Id.*) He noted he "was assuming that the computer screen would be OK because [Grant] uses the computer at home"; however, the court notes Grant testified he *did not* have a computer at home. (*See* R. 82)

Grant's attorney asked the VE to assume the limitations contained in the above hypothetical, but to add the fact that the individual takes anti-seizure medications that create a lack of alertness and lethargy. The VE stated that could eliminate all of the jobs he had listed, "depending on the degree of lethargy, the degree of lack of concentration." The VE noted all of the listed jobs "are going to require concentration and a degree of attention to detail on an on-going basis. If he's unable to meet that standard, as vague as it may be, he would be unable to [perform] these jobs or probably any others." (R. 95-96) The court notes Grant testified his medications did not cause him any problems. (*See* R.

78) Presumably, if the medications caused him to be lethargic or to have difficulty concentrating, he would have testified to those problems.

On the other hand, the VE stated if the individual had one seizure per week that required one to two hours of recovery time, that would not necessarily preclude him from the listed jobs. The VE explained:

> I'm just looking at a couple of hours a week, if we multiply that out per month. Typically if you miss more than one or two days per month absenteeism or unable to function on the job that would be similar. So you're really talking about you'd be losing a day, maybe a little more than a day a month. The fact that it would be something that couldn't be assumed that he was going to have at a certain time, couldn't be orchestrated where he could put another worker on the job at – you know – at 11:00 on Tuesday. That may be somewhat of a factor as well, but it doesn't sound [like] that factor alone would necessarily preclude employment because I don't think he would be losing that much time. You would have to have some accommodation from the employer, [I] think, in order to maintain employment.

(R. 96) The VE stated the same conclusion would apply if the individual had to doze or fell asleep for five to ten minutes once each day. Although it would be better for the individual to miss a half hour at a time, as opposed to ten minutes at a time, three times per day, the brief breaks still would not necessarily preclude work in the listed jobs except for cashier, which could be precluded depending on the nature of the job. (*Id.*)

The ALJ posed a second hypothetical question to the VE, as follows:

> My next hypothetical would be an individual of the same age, sex, education, past relevant work, impairments as previously specified. And this would be a person who had the residual functional capacity as follows: this individual could not lift more [than] 20 pounds, occasionally lift 10 pounds, and frequently lift 5 pounds; could not sit for more than 2 hours at a

> time; or walk for more [than] 1 mile at a time; or stand for more than 1 hour at a time. He can sit for about 2 hours in an 8-hour day, and stand or walk for about 2 hours in an 8-hour day. During an 8-hour day, once or twice he would need to take a break for approximately 30 minutes. He can only rarely crouch, or climb stairs, with no climbing of ladders, and he should not work at more than moderate stress, he should avoid work at unprotected heights or around hazardous moving machinery, and he should not be exposed to excessive heat or humidity, or perform work requiring full peripheral field, or depth perception. Would this individual be able to perform any job that he previously worked at, either as he performed it or as it is generally performed within the national economy?

(R. 83) The VE replied that if the hypothetical individual could only sit for two hours a day and stand or walk for two hours a day, that would mean he could not work full time, and he therefore would be unable to return to any of his past relevant work. (R. 93-94) The VE noted there are jobs in the light range of work that the individual could do, but again, he could only work half time. (R. 94)

By the time the VE's testimony was concluded, the Record reflects that Grant was asleep in the hearing room. (R. 97)

4. The ALJ's decision

The ALJ found Grant had not engaged in substantial gainful activity since his alleged disability onset date of November 2, 1998. (R. 32, ¶ 2) He found Grant to have severe impairments consisting of "a seizure disorder, degenerative disc disease of the lumbosacral spine and left homonymous hemianopia" (R. 26; R. 32, ¶¶ 3 & 9), but found those impairments did not meet or medically equal the Listings. (R. 32, ¶ 4) The ALJ noted that none of Grant's treating or examining physicians had mentioned findings equivalent in severity to the criteria of any of the listed impairments. (R. 28)

The ALJ found Grant's subjective complaints regarding his limitations were not totally credible. (R. 32, ¶ 5) The ALJ found the Record did not contain medical evidence to substantiate Grant's claim of severe back pain. Noting that Grant "cooks, performs the household chores, mows the grass, weeds the garden and . . . does woodworking," the ALJ concluded, "If his back pain was of such a severity as to preclude him from working, [it] is safe to assume that he would also be unable to perform these household duties to the above extent." (R. 29)[2]

The ALJ discounted the opinion of Stephen D. Richards, D.O., one of Grant's treating physicians, to the extent that in Dr. Richard's opinion, Grant was limited to working a four-hour day, and would require unscheduled breaks once or twice a day. The ALJ stated Dr. Richards "provided no objective medical data to support his opinion," and "considering [Grant's] testimony concerning his daily activities, he is able to be active throughout the day without stopping for significant periods of time." (*Id.*)

The ALJ found the increase in Grant's seizure activity would not last for 12 months or more, given the ready availability of "[m]odern treatment," including "[p]otent anti-convulsants," "reliable methods to determine blood anticonvulsant levels," and the ability to precisely tailor anticonvulsant drugs to a person's needs. (R. 30) The ALJ observed, "Consequently, only a small minority of such individuals [are] precluded from engaging

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[2]After reviewing Grant's testimony regarding his limitations, the ALJ stated, "[T]he undersigned notes that [Grant] has an excellent work history, with continuous earnings *even prior to the time he alleges disability*." (R. 29; emphasis added) A claimant could be expected to have regular earnings *prior* to the alleged onset of a disability; the court is concerned with the period of time on and after that date. The court assumes this is a misstatement, and the ALJ meant to note Grant had regular earnings even *after* his alleged disability onset date of November 2, 1998. The Record indicates Grant continued to work as an animal control officer through September 1999, although the Appeals Council found his work after the alleged disability onset date did not constitute substantial gainful activity. (R. 6)

in substantial gainful activity because their conditions cannot be controlled by appropriate treatment." (*Id.*)

The ALJ also discounted the testimony of Grant's wife, noting her observations of Grant's behavior and subjective complaints did not establish that his behavior was medically imposed. The ALj concluded he was "not convinced that the testimony of Ms. Grant accurately reflects the extent of [Grant's] limitations." (*Id.*)

The ALJ assessed Grant's residual functional capacity as follows:

> [T]he undersigned finds [Grant] retains the residual functional capacity to perform less than a full range of light work but more than sedentary work. [Grant] can lift 20 pounds occasionally and 10 pounds frequently. He can continuously stand for one hour, walk a distance of one mile; and he can sit for one or two hours at a time. He should not continuously kneel or crawl; and he should avoid repetitive bending, stooping or squatting. [Grant] should also avoid excessive heat and humidity, as well as work at unprotected heights and around hazardous moving machinery. [Grant] should perform no work[] which requires either depth perception or peripheral fields.

(R. 31; *see* R. 32, ¶ 7) He found Grant was capable of returning to his past relevant work as a telemarketer and machine bagger. (R. 31; R. 32, ¶ 8) The ALJ therefore found Grant was not disabled at any time through the date of the decision, and he was not entitled to benefits. (R. 31; R. 32, ¶ 10)

5. The Appeals Council's decision

The Appeals Council granted Grant's request for review of the ALJ's decision, and concurred with the ALJ's findings and conclusions for the period prior to January 1, 2000, noting:

> Specifically, evidence supports that prior to that date, [Grant] retained the capacity to perform the following work activities: lift and/or carry 20 pounds occasionally and 10 pounds frequently; stand for 2 hour[s] continuously; walk a distance of 1 mile; sit for 1-2 hours at a time; no continuous kneeling or crawling; avoid repetitive bending, stooping, or squatting; avoid excess heat and humidity; avoid work at unprotected heights and around hazardous moving machinery; and work which requires depth perception or peripheral fields is precluded.

(R. 6; *see* R. 7-8, ¶ 3) However, contrary to the ALJ's opinion, the Appeals Council found this residual functional capacity precluded the performance of any of Grant's past relevant work. (R. 6; R. 8, ¶ 5) The Appeals Council also found the work Grant performed after his alleged disability onset date of November 2, 1998, was not "performed at a level which constitutes substantial gainful activity." (R. 6; R. 7, ¶ 1)

Turning to step five of the sequential evaluation process, the Appeals Council found Grant's "nonexertional impairments and/or restriction(s) did not significantly affect his capacity for the full range of light work," and he "could have made a vocational adjustment to work which existed in significant number in the national economy," citing cleaner/housekeeper, cafeteria attendant, and order caller as examples of jobs Grant could have performed. (R. 6; R. 8, ¶ 7)

The Appeals Council considered evidence submitted after the ALJ hearing, and noted that by January 1, 2000, Grant was experiencing frequent seizures despite his medications. The Appeals Council relied on the opinions of consulting neurologist Joseph L. Fermaglich, M.D. in finding Grant's seizure disorder met Listing criteria as of, but not prior to, January 1, 2000. (R. 7; *see* R. 8, ¶¶ 7 & 8) Dr. Fermaglich conducted a review of the Record at the Appeals Council's request on April 10, 2001, and a further review on March 20, 2002. (R. 339, 341) He concluded Grant's residual functional capacity for the

period from February 2, 1998, until January 2000, would have proscribed "activities of heights or under water or operating heavy equipment or motor vehicles, during which time if he lost consciousness he would result in injuries to other[s] or to himself." (R. 341) Otherwise, the doctor found no restrictions to Grant's activities prior to January 2000, but Grant's condition met or equaled the Listings as of January 1, 2000, and forward. (*Id.*)

The Appeals Council concluded Grant was disabled from and after January 1, 2000, but not prior to that date, and awarded him benefits as of January 1, 2000. (R. 9, ¶ 9)

II. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial

gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *accord Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added); *accord Weiler v. Apfel*, 179 F.3d 1107, 1110 (8th Cir. 1999) (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

B. The Substantial Evidence Standard

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra,* 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra,* 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier,* 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell, id.; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence

supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); *accord Pearsall,* 274 F.3d at 1217; *Gowell, supra*.

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

III. ANALYSIS

This case concerns Grant's claim for disability for the fourteen-month period from November 2, 1998, to January 1, 2000. Grant argues substantial evidence in the Record supports his claim that he has been disabled since November 2, 1998. Specifically, he argues the ALJ's hypothetical failed to include all of his impairments that are supported by the medical evidence; the ALJ improperly discounted his subjective complaints; and his impairments met the criteria of the Listings as of November 2, 1998. (*See* Doc. No. 12) The court will address each of Grant's arguments.

A. Appropriateness of Hypothetical Questions

Grant first argues the second hypothetical posed to the VE by the ALJ more accurately described Grant's limitations than the first hypothetical. The second hypothetical assumed he would only be able to work for a total of four hours per day. With that restriction, the VE found Grant would not be able to work more than half time. (R. 94) Grant bases his claim that the second hypothetical accurately reflects his residual functional capacity on the report of his treating physician, Dr. Richards. Grant argues it was improper for the ALJ to disregard the opinion of his treating physician. (*See* Doc. No. 12, pp. 4-8)

Dr. Richards completed a residual functional capacity questionnaire on July 21, 2000. (R. 285-93) *At that time*, Dr. Richards opined Grant could only sit and stand/walk for about two hours in an eight-hour work day, with normal breaks, and he would need to walk around for ten minutes per hour throughout the day. He noted Grant's seizures were occurring once per week, typically lasted two to three minutes, and were accompanied at various times by confusion for several minutes, severe headaches for one-half hour to two hours, biting his tongue, and fecal and/or urinary incontinence during the seizure. He

stated Grant's impairments likely would produce both good and bad days, and Grant would need more supervision than other employees. He estimated Grant would be absent from work due to his impairments or treatment about four times per month. (*Id.*) Notably, however, there is nothing in the Record to indicate Dr. Richards's opinion applied to the period from November 1998 to January 2000. On the contrary, his statements appear in the present tense, and obviously apply to his view of Grant's condition as of July 2000, when the doctor completed the evaluation. He gave no opinion that pointed to the period at issue here. The court finds nothing in Dr. Richards's report that constitutes substantial evidence contrary to the Commissioner's decision. The court overrules Grant's argument that the ALJ's hypothetical to the VE did not contain all of his impairments, and therefore finds the VE's opinion constitutes substantial evidence.

B. Weight of Grant's Subjective Complaints

Grant next argues the ALJ improperly discounted his subjective complaints, failing to make a proper *Polaski* analysis. In particular, he argues the ALJ failed to explain how his "daily activities are inconsistent with a diagnosis of degenerative disc disease and seizure disorder," and the ALJ "failed to discuss the side effects of [Grant's] anti-seizure medications." (Doc. No. 12, p. 11) On the former topic, the court finds the ALJ properly supported his opinion that Grant's condition was not as limiting as he claimed. Although Grant is correct that the ability to do light housework or spent an hour mowing the lawn is not equivalent to the ability to work full time, the Record indicates Grant not only could continue to work after November 2, 1998, he actually did so for ten months, until he lost his job as an animal control officer because he no longer qualified for a driver's license. The clear implication was that Grant would have continued in that job if he had been able to drive. In addition, Grant did not testify to doing "light housework" -- he stated he

vacuumed, and did "basically whatever needs to be done in the house." (R. 83) He enjoyed spending his time doing woodworking projects, which requires standing and operating light machinery for sustained periods of time.

With regard to the side effects of his medications, Grant again points to the report prepared by Dr. Richards in July 2000. At that time, Grant was taking a total of 400 mg. of Dilantin and 1200 mg. of Tegretol a day. He also was taking 4200 mg. of Felbatol, 20 mg. of Inderal, and 20 mg. of Accupril a day, and Midrin as needed for headaches. (R. 287; *see* R. 312) Dr. Richards stated these medication dosages would cause Grant to suffer from lethargy, a lack of alertness, trouble sleeping, and weight gain. (R. 287)

Dr. Britton observed that the "usual dose required by the general epilepsy population for these medications are Tegretol 600 mg. a day, and Dilantin 300 mg. a day." (R. 336) He noted that while many epilepsy patients are controlled with a single anticonvulsant medication, as of March 14, 2001, Grant was "inadequately controlled on two." (*Id.*) He went on to state that at his dosages in March 2001 (*i.e.*, 600 mg. of Dilantin and 1200 mg. of Tegretol a day), Grant's medications often would leave him sedated, "which renders him unable to carry out sustained tasks in a consistent or reliable fashion, as would be expected by an employer." (*Id.*) The logical implication of Dr. Britton's report is that someone on the "usual" dosages of medication would not have the same degree of sedation as someone on higher doses.

As of June 1998, when Dr. Britton noted Grant was doing well and had been seizure free for a year, Grant was taking 400 mg. of Dilantin and 600 mg. of Tegretol a day, as well as 3600 mg. of Felbatol and 20 mg. of Inderal a day, and Midrin as needed for headaches. (R. 306) Grant's dosage of Tegretol in June 1998 was the same as what Dr. Britton described as the "usual" dosage for the general epilepsy population. His dosage of Dilantin was only 100 mg. a day higher than the "usual" dosage. His Tegretol

and Dilantin dosages remained unchanged as of September 18, 1998. (R. 217) In April 1999, Grant's Tegretol level was "mildly low" (R. 307), and Dr. Britton recommended he increase his Tegretol to 1,000 mg. per day, while continuing at the same dosage level of Dilantin. (R. 308) Nevertheless, in June 1999, Grant asked his doctors to complete DOT forms for him so he could renew his driver's license. Dr. Britton noted it was "okay for [Grant] to drive from an epilepsy standpoint as he is seizure-free since successful epilepsy surgery" (R. 237), although the doctor reserved judgment about Grant's visual impairment. (*Id.*) On July 14, 1999, Grant obtained an opinion letter from D.J. Kingfield, O.D., stating Grant was qualified to drive within a five-mile radius of his home, and restricting his driving to daylight hours. (R. 205) If Grant were suffering disabling sedation from his medications, it seems reasonable to assume he would not have sought to renew his driver's license in July 1999. The court notes Grant's Tegretol dosage was back down to 800 mg. a day by October 1999 (R. 308), although Grant was beginning to have a repeated incidence of seizure recurrence by that time.

The records discussed above lead to a conclusion that the side effects from Grant's medications were not disabling prior to at least mid-July 1999, when he sought to renew his driver's license. There is insufficient evidence in the Record to conclude the side effects became disabling between July 1999 and January 1, 2000.

C. The Listing Criteria

Grant argues that as of November 2, 1998, his impairments met the criteria of Social Security Listing 11.03. He takes issue with the Appeals Council's statement that he remained seizure free from his surgery in 1994, "'until late 1999, when [his] seizures began to increase in frequency.'" (Doc. No. 12, p. 12, quoting R. 7) The court agrees the Appeals Council's statement was incorrect. As noted above in the summary of Grant's

medical records, he had a recurrence of seizures in August 1996, due to a low Phenytoin level. (R. 304, 334) There is some implication he continued to have seizures because at some point between August 1996 and August 1997, Dr. Sharbrough increased Grant's dosage of Felbamate. (*See* R. 247) When Grant saw Dr. Sharbrough on September 9, 1997, the doctor noted Grant had a possible complex partial seizure in July 1997. (R. 246, 305) However, from July 1997, to September 1999, the Record indicates Grant was seizure free. (*See* R. 305, 09/09/97 - patient seizure and aura free since July 1997; R. 242-43, 306-07, 06/04/98 - no seizures over past year; R. 236-37, 308-09, 06/24/99 - patient doing well with seizures and complying with medication regimen; R. 264, 09/21/99 - patient's seizure disorder is under good control)

Grant argues the EEG report from June 4, 1998, shows he was continuing to have seizures. (Doc. No. 12, p. 13) The court disagrees. The EEG report notes the results were "similar to the previous recording of 12-12-94," which was *after* Grant's 1994 surgery that rendered him seizure free for the next two years. (R. 335) Although the EEG confirmed a continuing diagnosis of epilepsy, there is no evidence in the Record to support Grant's assertion that the report indicated he was having seizures.

Despite the fact that the court does not find any of Grant's arguments persuasive, standing alone, the court nevertheless finds the Record contains substantial evidence to support a finding that Grant was disabled due to seizures as of September 1, 1999. The Record indicates Grant continued to work and to drive through August 1999, when he lost his license due to his visual limitations. In September 1999, he suffered a recurrence of seizure activity that progressed continually after that time, ultimately resulting in the implantation of a left vagal nerve stimulator in October 2000. The court finds the loss of his driver's license tipped the scale in favor of a finding that Grant no longer was able to work in any type of gainful employment. Prior to that time, the court finds the Record

contains substantial evidence to support the Commissioner's conclusion that Grant was able to work and was not disabled. Although the Appeals Council noted that, in fact, Grant had not engaged in substantial gainful activity from November 2, 1998, forward, the court nevertheless finds the evidence in the Record supports a finding that Grant was *capable* of substantial gainful activity from November 2, 1998, until September 1, 1999, and was not disabled during that time period.

IV. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[3] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be reversed, judgment be entered for the plaintiff, and this matter be remanded for a calculation and award of benefits to Grant for the period from September 1, 1999, to January 1, 2000.[4]

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[3]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

[4]**NOTE TO PLAINTIFF'S COUNSEL:** If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.

IT IS SO ORDERED.

DATED this 1st day of December, 2003.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT